TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
MAGNOLIA STRONG GROUP, INC.

Respondent Name
Safety National Casualty Corp.

MFDR Tracking Number
M4-17-0189-01

Carrier's Austin Representative
Box Number19

MFDR Date Received
September 26, 2016

REQUESTOR'S POSITION SUMMARY

1. **Requestor's Position Summary:** "Our office received a partial payment regarding the aforementioned patient . . . Please review and remit the additional payment . . . "

Amount in Dispute: $987.39

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier did not submit a response for consideration in this review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 27, 2016 to July 22, 2016	Brain Injury Rehabilitation Services	$987.39	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guideline for professional medical services.
3. 28 Texas Administrative Code §133.250 allows for requesting reconsideration of carrier final action on a bill.
4. The division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, receipt acknowledged October 4, 2016. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier has not responded. Accordingly, this decision is based on the information available at the time of review.

5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P1 – (P12) Workers' Compensation Jurisdictional Fee Schedule Adjustment
   - 18 – Duplicate claim/service.

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment for the services in dispute?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code P1 – "(P12) Workers' Compensation Jurisdictional Fee Schedule Adjustment," and 18 – "Duplicate claim/service."

   Review of the submitted information finds that no bills were sent requesting payment for duplicate codes or services, but rather the health care provider requested reconsideration of the insurance carrier's final action under Rule §133.250. Consequently, claim adjustment reason code 18 "duplicate claim/service" is not supported.

   The insurance carrier did not submit a position statement for review. Review of the explanations of benefits finds no further description or explanation for the carrier's payment reductions beyond that they have paid per the workers' compensation fee schedule.

   As the only remaining issues are fee issues, the disputed services will be reviewed for payment according to applicable division rules and fee guidelines.

2. This dispute regards payment of physical and cognitive therapy services including training in activities of daily living and community/work reintegration related to a Brain Injury Rehabilitation Program with reimbursement subject to the division's *Medical Fee Guideline for Professional Services*, at 28 Texas Administrative Code §134.203, which requires that to determine the maximum allowable reimbursement (MAR), system participants shall apply Medicare payment policies with minimal modifications as set forth in the rule.

   Rule §134.203(c) specifies that:

   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. . . .

   (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year.

3. The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by a conversion factor. The MAR is calculated by substituting the division conversion factor.

   The applicable division conversion factor for calendar year 2016 is $56.82.

   Reimbursement is calculated as follows:

   - Therapeutic activities, 97530, has a relative value (RVU) for work of 0.44 multiplied by the geographic practice cost index (GPCI) for work of 1.005 is 0.4422. The practice expense (PE) RVU of 0.53 multiplied by the PE GPCI of 0.995 is 0.52735. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.772 is 0.00772. The sum of 0.97727 is multiplied by the Division conversion factor of $56.82 for a MAR of $55.53. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure has the highest PE for this date. The first unit is paid at $55.53. The PE reduced rate is $40.55 at 3 units is $121.65. The total is $177.18.

- Cognitive skills development, 97532, has a relative value (RVU) for work of 0.44 multiplied by the geographic practice cost index (GPCI) for work of 1.005 is 0.4422. The practice expense (PE) RVU of 0.3 multiplied by the PE GPCI of 0.995 is 0.2985. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.772 is 0.00772. (Note: Medicare does not designate this an "always therapy" code; it is not subject to multiple procedure payment reduction for therapy services.) The sum of 0.74842 is multiplied by the Division conversion factor of $56.82 for a MAR of $42.53 at 12 units is $510.36.
- Self care management training, 97535, has a relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1.005 is 0.45225. The practice expense (PE) RVU of 0.52 multiplied by the PE GPCI of 0.995 is 0.5174. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.772 is 0.01544. The sum of 0.98509 is multiplied by the Division conversion factor of $56.82 for a MAR of $55.97. Per Medicare policy, this code is subject to multiple procedure payment reduction for therapy services. Payment is reduced by 50% of the practice expense. The PE reduced rate is $41.27 at 4 units is $165.08.
- Community/work reintegration, 97537, has a relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1.005 is 0.45225. The practice expense (PE) RVU of 0.38 multiplied by the PE GPCI of 0.995 is 0.3781. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.772 is 0.01544. The sum of 0.84579 is multiplied by the Division conversion factor of $56.82 for a MAR of $48.06. Per Medicare policy, this code is subject to multiple procedure payment reduction for therapy services. Payment is reduced by 50% of the practice expense. The PE reduced rate is $37.32 at 4 units is $149.28.

The total MAR is $1,001.90 per date of service. The services, charges, and units are identical for each bill for each date. There are eight dates of service in dispute. The total MAR for all eight dates of service is $8,015.20.

4. The total maximum allowable reimbursement for the services as billed is $8,015.20. The requestor presented documentation to support that the insurance carrier has paid $8,284.17, leaving an amount remaining due to the requestor of $0.00.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The division would like to emphasize that the findings and decision in this dispute are based on the evidence presented by the requestor and respondent available at the time of review. Even though all the evidence was not discussed, it was considered.

For the reasons stated above, the division finds that the requestor has failed to establish that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	April 28, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.